*Capital Payment Continued.*

**5440 Calculation for Major Border Status Hospitals**

*Base Cost Report.* For major border status hospitals, the capital cost payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months. Cost reporting requirements are described in §4022.
An administrative adjustment is provided in section 11900, item C, for major capital expenditures incurred after the beginning of the base cost reporting period.

For combining hospitals, section 5480 below describes the cost report to be used for calculating the capital payment.

*No Audited Cost Report Available.* For hospitals for which there is no audited cost report available, an estimated capital payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The capital payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

*Calculation.* A capital payment for a major border status hospital is determined as described above for Wisconsin hospitals from cost information from each individual hospital's base cost report. For item 1, the Department determines "the inpatient cost attributable to WMAP recipient inpatients". The hospital may request an administrative adjustment under section 11900, item A, to correct for incomplete or incorrect data used in the Department's calculations. An example calculation is in section 23000 of the appendix.

**5450 Exemption From Capital Reduction of Section 5430, Item 2.**

Item 2 of above section 5430 specifies a percentage by which capital costs are reduced. In order to assure reasonable access to needed inpatient hospital services for WMAP recipients in rural areas, a Wisconsin hospital and a border status hospital which meet the following criteria is exempted from the capital reduction in their capital payment calculation. A list of hospitals qualifying for the exemption is in the appendix, section 21000.

To qualify for this exemption, a facility must be both outside a federally designated Metropolitan Statistical Area (MSA) and further than thirty minutes travel time from any other general acute care hospital. In determining thirty minutes travel time, the WMP will generally consider distances equal to or greater than 25 miles.

If the federal government makes a change in the designation of an MSA, which affects any hospital pursuant to this subdivision, the Department will recognize the change for the next annual rate update.

**5480 Cost Reports For Recent Hospital Combinings**

A "hospital combining" is the result of hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals for which there is not an audited cost report available for the combined operation, an estimated capital payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The capital payment will be adjusted retrospectively when an audited cost report for a full fiscal year of the combined operation becomes available to the Department. The capital payment adjustment is effective the first day of the month following the month in which the combination was consummated.

## 5500 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM

### 5510 General

As of July 1, 1997, an amount is added to a hospital's specific base DRG rate for costs of its direct medical education program. This payment amount is prospectively established based on an individual hospital's past direct costs of its medical education program. Prior to July 1, 1997, direct medical education program costs were paid under a prospectively determined monthly payment amount without regard to the number of WMP recipient discharges during the month.

### 5530 Calculation for Hospitals Located In Wisconsin

*Base Cost Report.* For hospitals located in Wisconsin, the direct medical education payment is determined from a hospital's most recent audited cost report on file with the Department as of the April 30th prior to the annual rate update. However, the Department may, at its option, use an audited cost report it receives later if the end date of the period of the cost report on file with the Department as of the April 30th date precedes the beginning date of the rate year by more than three years, three months.

If the cost report on file is more than three years old, the hospital may request an administrative adjustment to the direct medical education payment amount pursuant to §11900, item B.

Significant changes in a hospital's direct medical education program costs after the base cost reporting period may be considered pursuant to the available administrative adjustment under section 11900, item D.

For combining hospitals, section 6480 below describes the cost report to be used for calculating the capital payment.

*No Audited Cost Report Available.* For hospitals located in Wisconsin for which there is no audited cost report available, an estimated direct medical education payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The direct medical education payment will be adjusted retrospectively when an audited cost report becomes available to the Department.

*Calculation.* The direct medical education payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report. An example calculation is in section 24000 of the appendix.

1. The direct medical education cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient direct medical education costs to total allowed inpatient costs.
2. The resulting amount is inflated through the rate year by the DRI/McGraw Hill, Inc. HCFA Hospital Market Basket inflation rate and increased by any disproportionate share adjustment percentage applicable to the individual hospital.
3. The resulting gross amount is divided by the number of WMP recipient discharges for the period of the audited cost report.
4. The resulting amount per discharge is divided by the average DRG case mix index per discharge.
5. The result is the hospital's specific base payment for its direct medical education program at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.

Payment for a specific patient's stay is determined by multiplying the base payment amount by the DRG weighting factor for a specific patient's stay.



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**6480 Cost Reports For Recent Hospital Combinings**

A "hospital combining" is the result of hospitals combining into one operation, under one WMP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals for which there is not an audited cost report available for the combined operation, an estimated direct medical education payment is calculated based on the best available hospital data, as determined by the Department, such as an unaudited cost report or financial statements. The capital payment will be adjusted retrospectively when an audited cost report for a full fiscal year of the combined operation becomes available to the Department. The capital payment adjustment is effective the first day of the month following the month in which the combination was consummated.

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## 5600 SAFETY NET

With implementation of a DRG payment system, the potential exists for some providers to receive less in WMAP reimbursement than under the prospective rate-per-discharge system. The Department has established an automatic one year safety net/ceiling provision that provides a floor on the amount of loss any provider would be required to take and a ceiling on the amount of profit any provider would be allowed to retain. The WMAP intends to not have any one provider experience severe financial hardship in the first year due solely to the changeover to DRG reimbursement. In order to prevent major (more than 10%) shifts in Medicaid funding due to the initiation in the first year of DRG reimbursement, the State will calculate the amount of payment each Wisconsin hospital receives, net of inflationary rate increases, at the end of calendar year 1991. A sliding scale is established to define the safety net, and may be found in appendix, section 25000.

For a hospital which, during the first year of DRG payment, can document that it would have a substantial amount of reimbursement due under the safety net based on the calculation in appendix, section 25000, a request for an interim payment, along with verifiable data will be considered. Requests for interim payment are limited to one per quarter, and must be made directly to the Director of the Bureau of Health Care Financing. The WMAP will reconcile at year end, and issue a payout or recoupment as necessary.

Six months after the end of the first year of DRGs (July 1992), the Department will calculate and make whatever adjustment is indicated. The calculation will be based on all payments made for all DRG claims processed for discharges in the first year (calendar year 91) of DRG reimbursement. Claims processed after the date the Department does its calculations may be considered upon written request of an affected Wisconsin hospital. The data must show that a substantial number of claims (2% or more of total inpatient claims) and a significant fiscal impact ($20,000) to the hospital occurred after the WMAP made its calculation for the safety net. An example of the safety net calculation is presented in appendix, section 25000.

## 5700 HOLD HARMLESS

For hospitals with no prior experience under Medicare's DRG payment system, i.e., children's hospitals and IMDs, the State has provided for a "hold harmless" provision. The provision will guarantee that these hospitals will not receive less in calendar year 1991 payments under DRGs than they would have received under the rate-per-discharge system it replaced. The potential loss is zero, but the potential gain is limited to 5%. An example of the hold harmless provision is presented in appendix, section 26000.

Six months after the end of the first year of DRGs (July 1992), the Department will calculate and make whatever adjustment is indicated. The calculation will be based on all payments made for all DRG claims processed for discharges in the first year (calendar year 91) of DRG reimbursement. Claims processed and paid after the date the Department does its calculations, and which were not considered in the calculation, may be considered upon written request of an affected hospital.

An interim payment during the first year of the DRG payment system (no more than once per quarter) may be granted, upon application by a hospital that is supported by data. The data must show that a substantial number of claims (2% or more of total inpatient claims) and a significant fiscal impact ($20,000) to the hospital occurred after the WMAP made its calculation for the hold harmless.

A hospital eligible for both the hold harmless and the safety net provisions may choose one option, but must have indicate in writing its choice to the WMAP (Director of the Bureau of Health Care Financing) by June 30, 1991.
Hospitals certified by the WMAP with an effective date on or after January 1, 1991 are ineligible for special treatment under this paragraph. Hospitals created by merger, consolidation or acquisition are similarly not eligible for the hold harmless provision of this paragraph.

## 5800 OTHER PROVISIONS RELATING TO DRG PAYMENTS

### 5810 Medically Unnecessary Stays, Defined

Medically unnecessary stays are those stays that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See WIPRO review section below regarding criteria.)

### 5813 Authority For Recovery

The Department will recover payments previously made or deny payments for medically unnecessary hospital stays and/or inappropriate services based on determinations by the Department, the Wisconsin Peer Review Organization (WIPRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMAP recipients and payments made to providers of such services. Wisconsin statute, section 49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

### 5816 WIPRO Review

The Department has contracted with the WIPRO to review selected hospitalizations of WMAP recipients for medical necessity and appropriateness. The process to select those hospitalizations which are reviewed is approved by the Department. The WIPRO review criteria are premised on objective clinical signs of patient illness and documentation that intensive hospital services were being provided. The WIPRO review process represents a highly professional, clinically sound approach for assuring that hospital services are used only when medically necessary. WIPRO criteria is approved by the federal Health Care Financing Administration. The review criteria and periodic updates to it are disseminated to all hospitals in the state.

### 5819 WIPRO Control Number

The hospital must contact WIPRO and acquire a unique case-specific control number from the WIPRO for each of the following types of inpatient admissions:

- AODA admissions to general hospitals or hospital IMDs,
- elective psychiatric admissions to general hospitals or hospital IMDs,
- urgent/emergent admissions to hospital IMDs for recipients under 21 years of age,
- medical elective admissions, and
- admissions for ambulatory/outpatient procedures identified by the Department as needing control numbers.

Payment of inpatient claims for these admissions will be denied if the claims do not include the required case-specific control number from WIPRO.

### 5823 Inappropriate Inpatient Admission

Payment for inpatient care which could have been performed on an outpatient basis shall not exceed the facility's outpatient rate-per-visit paid under section 4.19B of the Medicaid Hospital State Plan. If payment has been made, the difference between the payment and the outpatient rate-per-visit will be recovered.

**5826 Inappropriate Discharge And Readmission**

If WIPRO determines that it was medically inappropriate for a patient to have been discharged from a hospital and as a result, that patient needed to be readmitted to a hospital, no payment will be made for the first discharge. If payment has been made, it will be recouped.

**5829 Transfers**

Patient transfers may be reviewed by WIPRO or the Department for medical necessity. If the transfer is determined to have been medically necessary, then both the transferring and the receiving hospital will be paid the full DRG amount for their discharge.

**5836 Days Awaiting Placement**

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. A DRG weighted discharge payment will not be adjusted for days a WMAP recipient patient awaited placement to an alternative living arrangement. If placement to a NF or an ICF-MR is delayed, not on the hospital's part, for completion of required pre-admission screening for mental illness and/or mental retardation (required under Subtitle C, Part 2 of PL 100-203, the Omnibus Budget Reconciliation Act of 1987), the hospital may request and receive a per diem payment for each allowed day identified as waiting placement due to the lack of the pre-admission screen. This payment shall be in addition to the DRG payment, not to exceed the estimated statewide average NF rate. Each allowed day awaiting placement must be adequately documented for review in the patient chart.

**5839 DRG Validation Review**

As part of the WIPRO review process, the information provided on the hospital claim are verified with the medical record documentation. This review may determine that the DRG initially assigned to the hospital stay was inappropriate. The Department may adjust DRG payment pursuant to the result of WIPRO reviews and recover any overpayment which has been made.

**5843 IMD Hospital Transfers**

An inpatient at an IMD may transfer to an acute care general hospital for a short term stay, then return to the IMD and eventually be discharged from the IMD. If the person's absence from the IMD is due to the person being an inpatient of one or more acute care hospitals for a period of three or less consecutive days, the IMD will not be paid a separate DRG discharge payment for the transfer to the acute care hospital. If the absence is for a period exceeding three consecutive days, the IMD will be paid a separate DRG discharge payment for the transfer to the acute care hospital. Three or less consecutive days means the patient is absent or on-leave from the IMD for three or less successive midnight census counts of the IMD.

The IMD will be eligible for a DRG based discharge payment upon the eventual discharge of the patient from the IMD. The acute care hospital, to which the patient was transferred, will be reimbursed for the medically necessary stay without regard to the patient's length of the stay in the acute care hospital. Any payment to the IMD for a person's inpatient stay is subject to the person being eligible for MA coverage for their stay in the IMD.

**5846 Outpatient Services Related To Inpatient Stays**

Outpatient hospital claims for services provided to a recipient during an inpatient stay are considered part of the inpatient stay and will be denied. Emergency room services shall be considered part of the inpatient stay, not outpatient services, if the patient was admitted and counted in the midnight census. Outpatient or professional claims on the date of admission or discharge will be allowed if billed by a provider other than the admitting inpatient hospital.



Substitute page

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**5849 Obstetrical And Newborn Same Day Admission/Discharge**

A hospital stay shall be considered an inpatient stay when a WMAP recipient is admitted to a hospital and delivers a baby, even if the mother and the baby are discharged on the date of admission and not included in the midnight census. This consideration applies to both the newborn infant and the mother and also applies in those instances when the recipient and/or newborn is transferred to another hospital.

**5853 Changes of Ownership**

Payment rates will not change solely as a result of a change of ownership. At the time of ownership change, the new owner will be assigned the hospital-specific DRG base rate, the capital payment and the direct medical education payment of the prior owner. Subsequent changes to the hospital-specific DRG base rate, the capital payment and direct medical education payment for the new owner will be determined as if no change in ownership had occurred, that is, the prior owner's cost reports will be used until the new owner's cost reports come due for use in the annual rate update.

**5856 HMO/PEI Alternative Payment**

The Department may establish a reimbursement methodology to pay hospitals directly for the inpatient care of AFDC recipients enrolled in health maintenance organizations in counties where the HMO Preferred Enrollment Initiative (PEI) is mandatory. This reimbursement shall be a prospective DRG, rate-per-discharge or rate-per-diem, depending on the type of hospital, based on MA HMO hospital costs deflated to the base year, adjusted and indexed for the authorized rate increases. The cost of this inpatient care shall be deducted from the HMO capitation rate paid to HMO's.

**5860 Cost Report Used For Recent Hospital Combinings**

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. Data from the audited cost reports of each previous (i.e., before the combining) individual hospital will be combined to calculate the following components of the hospital payment rates which require the use of cost report data: (a) the disproportionate share hospital adjustment under section 5243, (b) the rural hospital adjustment under section 5260, (c) the cost-to-charge ratio used for outlier payments under section 5322. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used for the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available. (For capital and medical education payments for combined hospitals, see §5230, §5430, §5440, §5530, and §5540)

**5862 Provisions Relating to Organ Transplants**

*Prior Authorization and Criteria.* In order for a hospital to receive payment for transplant services, the following criteria must apply:

a. The transplant must be performed at an institution approved by the WMAP for the type of transplant provided. A list of approved hospitals is available from the Bureau of Health Care Financing, P. O. Box 309, Madison, WI 53701-0309.
b. The transplant must be prior authorized by the Department. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.
c. In order to include the acquisition costs in the allowable charges, and not have the "acquisition costs" deducted from the transplant payment rate, the hospital will have to provide assurance to the Department that organs are procured from an organ procurement organization.

*Organ Procurement.* Organs must be obtained in compliance with the requirements of federal and state statute and regulations.

*Transplant Log.* Hospitals which perform organ transplants must maintain a log for every organ transplant performed for a WMAP recipient (except bone marrow) indicating the organ procurement organization or agency or source of the organ and all costs associated with procurement. A copy of this log must be submitted along with the transplant hospital's Medicaid cost report, so that the WMAP may document compliance.

**5900 Reimbursement for Critical Access Hospitals**

Definition: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by HCFA, and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

**Calculation of Reimbursable Critical Access Hospital Cost: A critical access hospital's costs will be audited for a fiscal year to determine the cost of providing inpatient hospital services for Medicaid recipients. The Department will also determine the total amount of DRG based payments made to the critical access hospital for discharges of Medicaid recipients during the respective year. Medicaid costs will be compared to payments.**

**If payments exceed costs, the Department will not recover excess payments from the hospital. However, excess payments may be applied to any amount owed to the hospital under the critical access hospital outpatient reimbursement provisions.**

**If costs exceed payments, the Department will reimburse the hospital the amount by which a hospital's costs exceed payments after such amount is reduced by the amount, if any, by which payments exceed costs under the Outpatient Hospital State Plan section 5100 relating to critical access hospital outpatient reimbursement.**

**Total inpatient payments may not exceed charges as described in section 9000.**

# SECTION 6000
# HOSPITALS PAID UNDER PER DIEM RATE

## 6100 COVERED HOSPITALS

Rehabilitation hospitals, state-operated IMD hospitals, and state operated veterans' hospitals will be paid under a rate per diem. Services described in section 7000 are exempted from reimbursement under this section if reimbursement is requested by and approved for the hospital according to section 7000.

## 6200 PAYMENT RATES FOR STATE MENTAL HEALTH INSTITUTES

This section 6200 describes how hospital institutions for mental disease owned and operated by the State are reimbursed for services provided Medicaid recipients. Reimbursement for inpatient hospital services will be a final reimbursement settlement for each hospital's fiscal year based on the hospital's allowable cost incurred in its fiscal year. All services provided during an inpatient stay, except professional services described in section 6480, will be considered inpatient hospital services for which payment is provided. Professional services described in section 6480 may be included in the final reimbursement settlement if a waiver or variance is approved under the procedures described in section 6258.

### 6210 Interim Rate Per Diem

Patient stays in a hospital covered by this section will be paid at interim or temporary rates per diem until a final reimbursement settlement can be completed for the hospital's fiscal year. The interim rate effective in a rate year, July to June, will be based on the interim rate per diem paid on June 30 of the prior rate year excluding any disproportionate share adjustment of section 5240. (The rate paid on the June 30 prior to the effective date of this change in reimbursement methodology will be the base for the interim rate effective on the effective date of this change.) The June 30 rate will be adjusted by the inflation multiplier from section 27200 that is listed under the fiscal year end date that coincides with the above June 30 date. The result will be increased by any disproportionate share adjustment for which the hospital may qualify under section 5240. The resulting interim rate will be increased if the hospital justifies an adjustment based on its historical expenses or expected expenses. The Department may at any time decrease the interim rate if it determines federal upper payment limits may be exceeded.

### 6220 Final Reimbursement Settlement

After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for Medicaid inpatient services provided during the year. The allowable costs a hospital incurred for providing Medicaid inpatient services during its fiscal year will be determined from the hospital's audited Medicaid cost report for the fiscal year. Allowable costs will include the net direct costs of education activities incurred by the hospital as determined according to 42 CFR δ413.85. Covered education activities include those allowed under δ413.85 and approved residency programs, allowed under 42 CFR δ413.86, in medicine, osteopathy, dentistry and podiatry.

A disproportionate share hospital (DSH) adjustment will be determined according to section 5240 if the hospital meets the qualifying criteria of that section. The DSH adjustment percentage will be applied to the allowable cost of Medicaid inpatient services for the fiscal year to determine the hospital's DSH payment. To calculate the adjustment percentage, the formulae and related fixed variables of section 5240, that were in effect on the July 1 date in the hospital's fiscal year, will be applied to the patient utilization incurred by the hospital in its fiscal year.

The final reimbursement settlement will take the following federal payment limits into consideration:

- Total final reimbursement may not exceed charges according to section 9000.
- Compliance with the federal upper payment limit of 42 CFR δ447.272, also known as the Medicare upper-limit, will be retrospectively determined when the final settlement is determined. If necessary, final reimbursement will be reduced in order that this federal upper payment limit is not exceeded.
- The hospital's disproportionate share payment may not exceed the limits of section 9100 which will be determined based on the hospital's fiscal year cost report used for the final settlement.
- Disproportionate share payment in the final reimbursement will be reduced, if necessary, to not exceed the State's limitations on aggregate payments for disproportionate share hospitals under 42 CFR δ447.297.

If the total amount of final reimbursement, including DSH payment, for the hospital's fiscal year exceeds the total interim payments for the year, then the difference will be paid to the facility. The difference will be recovered if the total final reimbursement, including DSH payment, is less than the total interim payments.

The above reimbursement methodology is being implemented effective on a date that might not be the beginning date of a covered hospital's fiscal year. That is, the first months of such a hospital's fiscal year will not be covered, while the latter months are covered by the cost settlement. In such a case, the hospital's Medicaid allowable cost for its full fiscal year will be prorated between the months not covered and months covered by this reimbursement methodology based on the number of Medicaid inpatient days in each period.

## 6250 PAYMENT RATES FOR STATE OPERATED VETERANS HOSPITALS

This section describes how a hospital owned and operated by the Wisconsin state government's Department of Veteran Affairs (DVA) will be reimbursed as of January 1, 1998. Reimbursement for inpatient hospital services will be a final cost settlement for the hospital's fiscal year based on the hospital's audited cost report for the fiscal year and subject to a maximum amount per diem. The hospital will be paid at an interim rate until a final settlement can be completed for a fiscal year.

### 6251 Services Covered by Reimbursement Under This Section

All services provided during an inpatient stay, except professional services described in §6252, will be considered hospital inpatient services for which payment is provided under this §6250. (Reference: Wis. Admin. Code, HSS 107.08(3) and (4))

### 6252 Professional Services Not Covered by the Payment Under This Section

Certain professional and other services are not covered by the payment rate under this section. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB 92 hospital claim form. The following services are excluded, when the professionals are functioning in a capacity listed below. Cost will be included in the final settlement for any or all professional services listed below if the hospital requests and the Department approves a discretionary waiver or variance from this rule (see §6268).

- physicians
- psychiatrists
- psychologists
- physician assistants
- nurse midwives
- chiropractors
- dentists
- optometrists
- hearing aid dealers
- audiologists
- podiatrists
- independent nurse practitioners
- anesthesia assistants
- certified R.N. anesthetists

*Any of the following provided on the date of discharge for home use:*

- pharmacy, take home drugs
- durable medical equipment and supplies for non-hospital use
- specialized medical vehicle transportation
- air, water and land ambulances

### 6253 Maximum Rate Per Diem for Hospital Services

Reimbursement for inpatient hospital services will be a final cost settlement for the hospital's fiscal year. Payment for the cost of hospital services will be limited to the maximum amount per diem described in this section. The maximum payment per diem will be based on the Wisconsin Medicaid program payments to hospitals that are paid under the DRG-based reimbursement system of §5000, for hospital stays classified under the following specific diagnosis related groupings (DRGs): "alcohol/drug dependence with rehabilitation therapy" (DRG #436) and "alcohol/drug dependence, combined rehabilitation and detoxification therapy" (DRG #437). Payments for services provided in the rate year July 1, 1994 through June 30, 1995 will be used. The amount paid per day for each stay will be calculated. That is, the DRG based payment for a stay will be divided by the days for the stay, resulting in the amount paid per day for the stay. The average of these amounts paid per day is the base maximum rate per diem. This average or base amount will be inflated to the period of the settlement fiscal year by the inflation multiplier listed in the appendix §27200 that will inflate a year ended June 30, 1995 to the hospital's settlement fiscal year.

Capital related costs and direct medical education costs will not be included in and will not be subject to limitation by the maximum rate per diem. Capital and direct medical education is described in section 6256.

### 6254 Interim Hospital Rate Per Diem

An interim hospital rate per diem is a temporary rate paid for patient stays in a hospital during which the patient requires hospital care. It is temporary because a final settlement payment cannot be calculated. Services will be paid at an interim rate pending the final settlement for each fiscal year of the hospital. The interim rate will be at 70% of the maximum rate per diem described in §6253. It will be increased, not to exceed the maximum rate, if the hospital justifies an adjustment based on its historical expenses or expected expenses.

### 6255 Payment for Stay in Hospital for Recipient Awaiting Alternative Placement

Days awaiting placement are those days of a person's stay whose continued hospitalization is no longer medically necessary or appropriate during a period where the recipient awaits placement in an alternate custodial living arrangement. A rate per diem will be paid for days awaiting placement.



Substitute page